

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
STAKEHOLDER ADVISORY COMMITTEE (SAC)
Meeting #10 – Thursday, November 3, 2011
9:30am – 12:30pm**

The meeting was convened at 9:35 AM.

Attendance

Members attending: Kelly Brooks, California State Association of Counties (CSAC); Mike Clark, Kern Regional Centers; Ruth Gay, California Council of the Alzheimer's Association; Brad Gilbert, Inland Empire Health Plan (IEHP) (by phone); Marilyn Holle, Disability Rights California (DRC); Michael Humphrey, Sonoma County IHSS Public Authority; Eileen Kunz, On Lok Senior Health Services (by phone); Ingrid Lamirault, Alameda Alliance for Health; Elizabeth Landsberg, Western Center on Law & Poverty (WCLP); Marty Lynch, California Primary Care Association (LifeLong Medical Care); Anne McLeod, California Hospital Association (CHA); Steve Melody, Anthem Blue Cross; Sara Nichols, SEIU; Bob Prath, AARP California Executive Council; Sharon Rapport, Corporation for Supportive Housing (CSH); Lisa Rubino, Molina Healthcare of California; Timothy Schwab, SCAN Health Plan; Rusty Selix, California Council of Community Mental Health Agencies (CCCMHA); Al Senella, California Association of Alcohol and Drug Program Executives; Barbara Siegel, Neighborhood Legal Services of Los Angeles County (NLS); Stuart Siegel, Children's Hospital Los Angeles (CHLA); Marv Southard, Los Angeles County Department of Mental Health; Hermann Spetzler, Open Door Community Health Centers (by phone); Anthony Wright, Health Access California (by phone).

Others attending: Toby Douglas, DHCS; Jalyne Callori, DHCS; Len Finocchio, DHCS; Brian Hansen, DHCS; Jane Ogle, DHCS; Luis Rico, DHCS; John Shen, DHCS; Suzanne Fields, TAC-HSRI.

Public in attendance: 22 members of the public attended in person, and 132 attended via the listen-only call-in line.

Welcome, Introductions and Purpose of Today's Meeting

Toby Douglas, Director, DHCS, welcomed the group and introduced the agenda.

Douglas said that DHCS plans to have the Stakeholder Advisory Committee continue to meet in 2012, likely three times and with an expanded charge, addressing not only the 1115 waiver but other issues related to health care reform implementation more generally, and eligibility and enrollment in particular. DHCS does not have another venue for stakeholder

involvement in ACA-related work, and believes that given the close relationship between the ACA and the waiver, the SAC is a logical site for this discussion.

Barbara Siegel, LSC, supported the idea but suggested that an expanded scope would require a longer meeting. *Toby Douglas* agreed.

Marv Southard, LAC, agreed that integration of waiver and other ACA work would be a good idea. *Anne McLeod, CHA*, supported the idea of expanding the SAC's scope but asked whether it would replace other stakeholder groups, such as those convened by the Exchange. *Toby Douglas* said that while DHCS works closely with the Exchange, the SAC would remain a DHCS entity.

Bob Prath, AARP, said that materials presented to the SAC do not adequately address how the waiver programs will provide the bridge to reform.

Marty Lynch, CPCA/LifeLong Medical Care, suggested adding Triple Aim and health homes to the agenda, along with coverage expansion. *Rusty Selix, CCCMHA*, agreed and suggested that the work group model used earlier in the process be revived in order to address issues like health homes and integration.

Toby Douglas thanked members for input and said that DHCS would let the group know about 2012 agendas.

Douglas presented an overview of the waiver implementation process. The state budget crisis represents an extremely challenging time for Medi-Cal, since consequential payment reductions have now been approved. The process will be difficult, and DHCS will be monitoring the implementation of the cuts in order to ensure maintenance of access to care for beneficiaries. The transition of the ADHC population to other services is also requiring tremendous effort both from the Department and from communities. DHCS is currently engaged in settlement negotiations regarding ADHC. If the trigger cuts required as part of the 2011-12 budget deal do go into effect, they will have a significant impact on DHCS, mostly in the IHSS realm.

At the federal level, DHCS is following the progress of the Congressional supercommittee's deliberations and the possible effects on Medicaid financing. FMAP changes under discussion would shift costs back to the states. California is attempting to shift the discussion from the blunt implements of FMAP cuts to state strategies for reducing the costs of health care across the public *and* private systems, which would be in the best interests of all concerned.

With regard to the waiver in particular, DHCS and CMS have finalized the Statement of Terms and Conditions, with a few outstanding issues yet to be approved regarding rules for

payment of public hospitals. There are no financial implications for California, but some work still to be done to reach agreement. A few other issues, among them the integration of the Ryan White populations into the county LIHP programs, may lead to amendments to the waiver agreement.

Douglas introduced Len Finocchio, who joined DHCS in July from the California HealthCare Foundation. Finocchio will be working on health care reform broadly defined, including the DHCS interface with the Exchange and the California Affordable Coverage Enrollment System (CACES), the state's "single point of entry" for enrollment in all the subsidized health insurance programs.

Mike Humphrey, Sonoma County IHSS, asked whether there was any update on funding for home and community-based services (HCBS). Given the 90% federal match for health homes, what is the state's thinking about implementing that option? *Brian Hansen, DHCS* said that the Department is working with Health Management Associates and Mercer on an assessment of the section 2703 health home option, and expects to release some data from those evaluations in 2011. A link to an October webinar by Health Management Associates is available at:

<https://arkadin-demo.webex.com/arkadin-demo/lsr.php?AT=pb&SP=EC&rID=54582357&rKey=623cb0ef086c2c5d>.

The PowerPoint presentations from this webinar are available at:

<http://www.communityclinics.org/content/general/detail/1066>

With regard to the 90% FMAP in particular, that is available only for care coordination, not direct services. It is still an exciting opportunity to push care coordination for vulnerable populations.

Update on Implementation Efforts on SPDs

Jane Ogle, DHCS, presented information on the transition of Seniors and Persons with Disabilities into Medi-Cal managed care. Her presentation is available at

<http://www.dhcs.ca.gov/provgovpart/Documents/SPDTransition.pdf>.

Ogle noted that

- The state had expected monthly enrollment of approximately 24,000, but that dipped to 20,000 in October. Some whom DHCS had thought would be eligible weren't.
- Choice rates are at approximately 70%, when actual choice (stable at around 40%) and provider linkage (up from 15% early in the program to 32% now) are combined.

- Medical Exemption Requests (MERs) continue to be an issue. The policy allows people a year to transition. Some FFS providers don't understand that, and some specialty providers in particular are asking for MERs for all their patients. This is not necessary: providers have a year to work with the health plans to either contract or transition their patients. As a result of the high rate of MERs that come in with inadequate information, there is a backlog of deferred requests, though that is now down to a two-week turnaround.

Mike Humphrey, Sonoma County Public Authority asked whether DHCS has data comparing the SPD enrollment effort to previous ones. Is the 30% auto-enrollment statistic typical? *Toby Douglas* replied that the only comparison is two-plan model enrollment, and that choice rates for SPDs are similar or a little higher. As much as DHCS wishes everyone would make an active choice of plan, the Department is pleased that they can reach a 70% linkage rate through identification of a usual source of care.

Mike Humphrey asked for clarification on the 25% denial rate for medical exemption requests (MERs). Why are people being denied? *Jane Ogle* said that these determinations are made by medical experts, but possible reasons for denial would be that there are no continuity of care issues for that person or that it is judged that transition to the managed care plan would not interrupt care in any way. Stability and continuity of care are the criteria used by the medical reviewers. If a person has completed care, or the request is due to a need for durable medical equipment or something else that is easy to transition, those requests might also be denied. DHCS has recently put out new guidance on pregnancy-related MERs, which is posted on the website.

Barbara Siegel, Neighborhood Legal Services, said that she was shocked by DHCS' statement that "the transition has been smooth." She said that there are multiple enrollment problems for SPD beneficiaries, with serious consequences. Surgery, chemotherapy, and insulin treatments, among other critical services, have been disrupted.

The MERs form is defective, which may account for the high rate of deferrals and denials. The policy requires people to prove the need for an exemption, but the form does not say that any proof is required. As a result, when physicians receive requests for additional information, they are confused, while beneficiaries don't themselves receive the requests for information or the notices of denial.

Barbara Siegel said that she took exception to the way the statistics were presented. Many of the people who have deferred MERs are being transitioned into managed care plans anyway, in contravention of policy. The 70% linkage rate overstates the case – people may be linked to a usual source of care, but often not in the right IPA. Siegel said that HCO is

providing inaccurate information in some instances, and that while the ombudsman is very helpful, that office does not return calls. Overall, she said, the transition is not at all smooth.

Marilyn Holle, DRC, added that there is a defect in the denial notice, which is silent about the ability to maintain the status quo throughout the appeal process. She agreed with Barbara Siegel that HCO has been providing inaccurate information. In one case, a person who works with a team of specialists was told by HCO not to attach anything to the MERs, and that only one physician was allowed to submit a form.

Holle said she had concerns about the qualifications of the medical reviewers. A number of the people who are being transitioned are people with juvenile-onset illness and disability, which can be very complex. In one case, a nurse speaking to a reviewer about a patient on a transplant list was cut off when she tried to describe the situation. Under Knox-Keene, members have the right to have decisions made by people with appropriate qualifications.

Jane Ogle said that DHCS has been working with a variety of groups on the MER process and form, but Barbara Siegel said that the current draft still doesn't address all the problems. Jane Ogle asked Siegel to send her suggested changes. She acknowledged that there had been issues around approval of MERs for transplant patients.

Toby Douglas asked for a separate meeting to discuss specific plans, providers and cases. He said he understood that people who see these cases might take offense at the characterization of the transition as smooth, but said that the information DHCS has does not indicate such severe problems.

Elizabeth Landsberg, WCLP, said that consumer groups would welcome such a meeting. WCLP is finding that some physicians are finding it difficult to join plans' provider networks. She said that the problems are not only being seen in Los Angeles, and asked DHCS to provide an aggregate report on complaint to the ombudsman, HCO, and DMHC.

Toby Douglas asked plan representatives for their perspectives.

Lisa Rubino, Molina Healthcare, said that the SPD transition has been an extraordinary effort. DHCS did phenomenal work in advance, and the plans also worked very hard to prepare for the transition. Molina added many behavioral health staff, and is working around the clock on case management, helping members with issues like food and utilities, and receiving good feedback for that work. While there are certainly problems, a lot of the transition is going very well. Molina takes continuity requests through its medical review team, and does try to get people to sign up. She said that she believes that the plan has the right focus.

Steve Melody, Anthem Blue Cross, said that from an operational standpoint, his judgment that the transition is going well, though perhaps not very well. There have been problems, but there has also been intensive work to educate IPAs, for example, and the plan takes this work seriously.

Tim Schwab, SCAN Health Plan, said that SCAN does not cover this population, but asked whether DHCS had looked for trends in MER requests by geography or provider type. He said that this information would be important as the state moves to enroll dual eligible individuals. He asked whether the duals who are enrolled through this program are voluntary enrollees. *Jane Ogle* said that these people are part of the ADHC transition. As of October 1, 2011, ADHC beneficiaries were offered the option of passive enrollment in plans or choosing a plan, and about 11,000 made the choice.

Marty Lynch, CPCA/LifeLong, asked whether DHCS could supply statewide data on the percentage of people who are linked back to their existing primary care providers. *Jane Ogle* said that the slide titled Transitional Enrollment Results shows that in June 2011 15% of people were linked to their providers. By August, the rate reached 32-33% linked either to a primary care or specialty provider. She could not say whether and to what extent the plans themselves were able to make these linkages when the state did not.

Marty Lynch, CPCA/LifeLong said that the transition for his clinics' ADHC population was not smooth at all, and that people did not have adequate information in advance. [*Speaker undetermined*] said that both the state and the plans had worked hard at the process, but that they likely overestimated beneficiaries' health care system literacy. A significant percentage of the population continues to visit their FFS providers, who often just waive the \$15 fee and serve them anyway. The beneficiary often doesn't understand how to seek care through their new plan, and the FFS provider doesn't know where to send them. The state will be more prepared when it comes time to enroll duals in managed care.

Ingrid Lamirault, Alameda Alliance, said that her organization did encounter problems with choice and continuity of care early in the process, but that things are improving. The Alliance worked with DHCS to pick up the data that had previously been missed, in order to increase the choice rate, and has reached out to FQHCs and high-volume providers in order to improve linkages. She said that this population presents care coordination scenarios that the Alliance has never seen, and that they are addressing them by reaching out to other agencies for assistance.

Brad Gilbert, IEHP, said that his plan had been fortunate in terms of primary care connections, and have only had to sign agreements with providers who are *not* part of their network in a few cases. Typically, the primary care providers then join IEHP and the plan can then work with them to coordinate specialty care, though in a few cases a provider has

not been interested in working with the plan. If a member contacts the plan, they can work with them to determine if an MER makes sense, and if so to submit it. In most cases, this has not been necessary.

Toby Douglas, DHCS, said that Department would meet with advocates along with plan and provider representatives, in order to get all different perspectives.

Anne McLeod, CHA, said that SPD beneficiaries with both physical and behavioral health conditions typically need to disenroll from their plans when they need to transition to skilled nursing facilities (SNFs). That process can be difficult, however, resulting in people with dual diagnoses remaining in the hospital for months instead of in the SNF where they can receive the right level of care.

Ruth Gay, Alzheimer's Association, asked what plans could do to enhance people's safety. *Jane Ogle* said that plan contracts require that each beneficiary receive a full assessment at the time of transition.

Rusty Selix, CCCMHA, said that a 2004 White House report found that 25% of people who receive SSI have severe mental illness (SMI). He said he had asked during the waiver development process whether California had any such data, and that DHCS did not. He said that his member agencies serve these adults, and that linkage to appropriate health care has always been a problem. The waiver offers the opportunity to integrate care successfully, and to gather better data at the same time. Does the state have the capacity to track the SMI SSI population?

Sara Nichols, SEIU California asked for clarification of Jane Ogle's comment that a number of people whom DHCS had expected to be eligible for the transition turned out not to be. *Jane Ogle* replied that DHCS had underestimated the number in the population who had a share of cost for their coverage – only those with no share of cost are part of the transition population.

Toby Douglas added that people who file MERs prior to enrollment also are not enrolled. *Jane Ogle* clarified that the policy is that those who put in requests during the 90-day pre-enrollment period are supposed to remain in FFS until the MER is decided, while those who are enrolled first and then file an MER remain enrolled in the plan. *Marilyn Holle, DRC*, said that the Medi-Cal ombudsman office had told her the opposite: that unless pre-enrollment beneficiaries specifically request the status quo, they will be moved, without notice to the beneficiary.

Update on Implementation Efforts on LIHP

Jalynne Callori, DHCS, provided an update on the implementation of the Low Income Health Programs (LIHP). Her presentation is available at <http://www.dhcs.ca.gov/provgovpart/Documents/LIHP%20Implementation%20Presentation.pdf>. Additional information, including materials from the “Making It Happen Together” LIHP conference held on October 19, 2011, is available at <http://www.dhcs.ca.gov/provgovpart/Pages/lihp.aspx>.

Marty Lynch, CPCA/LifeLong, asked about capacity issues in the LIHP programs. He said that Alameda County has been a fantastic partner for LifeLong, and that after one quarter they are running way above the expected capacity, which challenges access to care for Medi-Cal clients. Have counties come up with good strategies to deal with people who would be eligible for LIHP but for whom there isn’t capacity in the safety net? *Jalynne Callori* replied that she understood that that was a concern for a number of counties, both those implementing and those reluctant to do so. How can counties maintain ongoing care for existing Medi-Cal beneficiaries if they take on the expanded benefit for the new LIHP population? While there is not yet a collection of best practices, DHCS is interested in talking about and collecting information on this topic.

Marv Southard, Los Angeles County, asked whether “inmate enrollment” as mentioned in the LIHP presentation is aimed at the AB 109 population and, if so, if the state could make an effort to address requirements around documentation of legal citizenship, which appears to be the primary obstacle to enrolling people in LIHP when they come to the county. He said that LAC wants to enroll all AB 109 returnees into the county LIHP, and easing documentation requirements would allow for people to have LIHP eligibility in place as they are released from custody.

Toby Douglas said that the inmate enrollment reference in the presentation is different, and refers to an effort to enroll state inmates in the LIHP as a way of covering their overnight hospital stays. That said, however, the LIHPs could use the same strategy for their county jail populations. With regard to AB 109, DHCS is engaged in facilitating discussions between the correctional and behavioral health sides.

Marv Southard, LAC, said that he had been in discussions with CDCR regarding expediting enrollment of AB 109 prisoners into LIHPs, and they have no resistance. However, it has been hard to figure out exactly how to make it happen and DHCS’ leadership would be appreciated. *Toby Douglas* suggested that CSAC might be able to help facilitate this work, and *Kelly Brooks, CSAC*, said that her organization was aware of the problem with documentation.

Sharon Rapport, CSH, said that documentation is also a problem for homeless people. If this population could be enrolled automatically into the LIHP, that would solve a number of

problems. She said that guidance from the state would be helpful in reducing the complexity of the enrollment process.

Elizabeth Landsberg, WCLP, said that while she would love to have people only face one application, the LIHP programs, unlike Medi-Cal, don't have assets tests and she would not want to require LIHP applicants to face that requirement unnecessarily. She asked whether DHCS has consulted with CMSP on this issue. *Jalynne Callori* replied that the assets test can't be part of the LIHP application, but that since that information is needed for Medi-Cal then applicants will need to provide it. Landsberg argued that since the Medi-Cal application, with assets test, has to be completed before the LIHP application, in effect the assets test is part of the LIHP requirements. *Toby Douglas* replied that it is not an eligibility requirement for LIHP, but is a screening requirement. Callori said that she is aware that some counties do require an assets screen for any county program, and that it is built into One-e-App.

Implementation Efforts for CCS Pilots

Luis Rico, DHCS, provided an update on the California Children's Services (CCS) demonstration projects. His presentation is available at <http://www.dhcs.ca.gov/provgovpart/Documents/CCSPilots.pdf>.

Stuart Siegel, CHLA, suggested that the pilot evaluations should consider what happens not only to the cost of care, but also to the administrative cost of the program. He asked what would happen to CCS children in counties where the pilot doesn't reach the entire county – would they remain in the current system or move to managed care. *Luis Rico* responded that children who are not in pilot counties will remain in existing FFS CCS program, but that CCS-eligible children in managed care counties will be enrolled in managed care plans for care for their non-CCS conditions. *Kelly Brooks, CSAC*, asked for clarification on this point – will children not participating in the pilot remain with the status quo? Will a child on SSI who has CCS continue to be exempt? *Toby Douglas* clarified that if a child is in an SPD aid code, that although DHCS held off enrolling that population pending the pilot decision, they are planning to move forward with enrolling the CCS population in those categories into managed care. In Los Angeles, if an SSI/CCS child is not in one of the pilot zip codes, they will be transitioning to a managed care plan.

Stuart Siegel, CHLA, said that Los Angeles County appears to be concerned about their ability to maintain services to children who are not enrolled in the pilot, as a result of funding reductions due to pilot implementation, and asked how DHCS intended to address this issue. *Luis Rico* acknowledged that this would be challenging, and said that DHCS is looking to resolve these challenges in a cooperative fashion.

Luis Rico said that pilot implementation will depend on a variety of factors, including readiness. January 2012 is an ambitious goal, but may be possible in some areas. Enrollment will be staggered.

Marilyn Holle, DRC, said that she remains concerned that the pilots ignore children from rural counties who receive care in urban counties that will be part of the pilot. For example, children in Kern, Kings and Tulare who need specialty care for CCS conditions typically come to Los Angeles for that care. Access to these providers must be carefully monitored. *Luis Rico* responded that the pilots will not affect the system for children from rural areas. Already, DHCS has made changes in Children's Medical Services regarding the service authorization process, and have developed a dependent county operations area, specifically for children in rural areas. While DHCS is aware of the need, they are working on it. Holle asked that rural children's access be included in any evaluation. *Luis Rico* said that Dr. Diamond, the CMS Medical Officer, chairs a CCS evaluation advisory committee that will be part of all evaluations. The committee includes approximately 25 individuals, including providers, county staff, and others. Stuart Siegel sits on the committee.

Barbara Siegel, NLS, noted that pediatric specialists are not included in most provider networks, and that DHCS should be engaging in planning to address that problem. *Luis Rico* clarified that the CCS carve-out would still apply: CCS conditions will be treated in the FFS environment.

Kelly Brooks, CSAC, asked whether DHCS was collecting baseline data on CCS. *Luis Rico* said that the evaluation committee and the UCLA evaluators would be looking at the baseline data that is already collected to ensure that it is appropriate for the pilot evaluations.

1115 Waiver Behavioral Health Assessment

Suzanne Fields, Technical Assistance Collaborative, presented on the Waiver Behavioral Health Assessment being conducted by the Technical Assistance Collaborative and Human Services Research Institute (TAC-HSRI). Her presentation is available at <http://www.dhcs.ca.gov/provgovpart/Documents/BehavioralHealthAssessment.pdf>.

Rusty Selix, CCCMHA, asked to what extent the report will present county-by-county details, and whether there will be a county stakeholder process. He said that the mental health community providers have asked for that specifically in plan development, but noted that it is also an issue in assessment. So much of the behavioral health decision-making and money are the county level that the state should build off a county-level process.

Suzanne Fields, TAC-HSRI, replied that data will be broken out by county where it is possible to stratify in that manner. Qualitative information will not be stratified, since the purpose is to be used thematically to inform deeper dives. She said she was interested in the county stakeholder idea and would like to hear how that could be accomplished within the time and resource constraints of the project. *Rusty Selix* said that he thought that the County Mental Health Directors could probably manage such a process.

Marv Southard, Los Angeles County, suggested comparing state and local treatment data. He said that in the past there had been a problem with mismatch of the data, since in many

counties MHSF funds have been used to treat substance abuse disorders of people with co-occurring disorders, but the treatments have been coded as mental health. As a result, there may be underreporting of county substance abuse efforts. *Suzanne Fields* said that it was for that reason that the project included the qualitative research piece, which allows investigators to pay attention to what the data doesn't offer. She said that this was also the reason that the prevalence report was the first task, since it gives a baseline for comparison.

Al Senella, California Association of Alcohol and Drug Program Executives, asked whether youth and adolescents would be part of the "deeper dive" on special populations. He also asked about those with co-occurring substance abuse and mental health disorders, and medical conditions that are barriers to getting care. *Suzanne Fields* said that children and families involved with the child welfare system are a special population that was omitted from the list in the presentation. She said that the research looks at co-occurring physical health problems, and examines medical utilization (and health home data) as well as behavioral health utilization.

Marty Lynch, CPCA/LifeLong, asked whether the research will look at frequent users of emergency departments. *Suzanne Fields* said that that was routine, and that this was not considered a special population. Sharon Rapport suggested that the study also call out frequent users of inpatient care.

Duals Demonstration Update

John Shen, DHCS, and *Jane Ogle, DHCS*, presented an update on the Duals Demonstration. Their presentation is available at <http://www.dhcs.ca.gov/provgovpart/Documents/DualEligiblesUpdate.pdf>.

Brad Gilbert, IEHP, noted that the Department has said that the federal government does not want to look only at special needs plans (SNPs), but cautioned that SNPs should not be ignored, as they do good work. *Jane Ogle* agreed, saying that CMS and DHCS both understand that SNPs have done a good job of coordinating the medical side, and said that the proposed program builds on that. CMS says that they will take some of SNP (including beneficiary and marketing protections) and then go beyond that.

John Shen said that California is looking at pooling Medicare and Medi-Cal resources to build a new system of care based on SNP. DHCS has bought a lot of nursing home and hospital care, and now wants to pool and coordinate resources – expertise and dollars – to coordinate medical and social/LTC services both for community-based and nursing home populations.

Toby Douglas noted that this is a huge and important project, and that DHCS is very fortunate to have Peter Harbage and his team working on it.

Stuart Siegel, CHLA, asked whether DHCS was considering converting Medi-Cal reimbursement to the Medicare schedule. *Toby Douglas* replied that for the services where

Medicare is primary, nothing in the proposal is about reducing payments – the rates they were receiving previously should stay the same, though the payment arrangement may be different. What will change is utilization, and the proposal is all about improving coordination and integration.

Ruth Gay, Alzheimer's Association, said that many duals have dementia, which complicates health delivery in multiple ways. She asked whether there will be access to mental health services for people with dementia. Will caregiver assessments occur as part of the behavioral health assessments? *Jane Ogle* replied that the behavioral health component of the integration is a significant piece of the overall project.

Mike Humphrey, Sonoma County, noted that the legislation authorizes up to four pilots, and asked what the state's long-range plan is for adding additional counties? *Toby Douglas* replied that DHCS is focused on moving as fast as possible. Humphrey asked how many IHSS clients are dual eligibles. Douglas said that approximately 80% are duals, but said that the Department plans an integrated benefit even for those who are not dually eligible. All of IHSS would be integrated in the pilot counties.

Humphrey asked how things would change operationally at the county level, and what the role of county social workers would be. Douglas said that this is a key question, and that with Peter Harbage's assistance DHCS will soon release different ideas for the project for public reaction and response. How could IHSS fit in this integrated system? How can IHSS' principles and consumer-driven care be preserved? Humphrey said that California should ensure that Medicare savings are captured to help save IHSS. The Nurse Practice Act poses a problem, and it is essential that the social character of the program is maintained. Douglas said that these are the conversations he wants to have: about the value of IHSS and the IHSS workforce, balancing their ability to do more than just IHSS work with consumer protections.

Barbara Siegel, NLS, noted that many duals are not dually eligible all year long, and asked how the state intends to handle eligibility. She also noted that advocates had just spent a year educating duals that they *don't* have to enroll, and said that waiting until October 2012 to begin informing them of the change would be a problem.

Marv Southard, LAC, asked about substance abuse treatment. *Jane Ogle* said that those services have been and will be part of the behavioral health discussion. Southard replied that they are two different systems at the state and county levels, so it is not possible to have just one conversation.

Rusty Selix, CCCMHA, said that he had spoken several times to Peter Harbage about two different populations: the duals due to psychiatric disability, who are in the public mental health system and don't have access to Medicare, and the other who don't need Medi-Cal, and should be outside the public mental health system. He suggested that there might be two different systems for reimbursement and care coordination for these two populations.

Al Senella, California Association of Alcohol and Drug Program Executives, said that the benefit for substance use services stinks on both the Medi-Cal and Medicare sides, and asked whether the pilot would be constrained or if it would be possible to explore something more constructive. *Toby Douglas* replied that this is a good question, that there isn't an answer, and that DHCS will need to consult CMS about the rules on benefit design. Overall, the reason to do this is to drive down the overall spend, but within that structure there might be places where expanded benefits help meet that goal.

Tim Schwab, SCAN Health Plan, asked whether DHCS envisioned keeping several models from the pilot phase, or picking one to expand statewide. *John Shen* said that they are looking for creativity at the county level regarding integration and coordination, but that they will probably standardize the benefit design.

Waiver Evaluation

Len Finocchio, DHCS, presented an update on waiver evaluation activities. His presentation is available at <http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Presentations/Waiver-Evaluation-Update.pdf>.

There were no questions or discussion.

Public Comment

Peter Hansell, California Association of PACE Programs, said that it was helpful to hear the Department's thinking as these projects proceed. He noted that California has existing programs, like PACE, that provide services to duals. How do these projects fit into the duals initiative going forward? Per the legislation, PACE is to be an enrollment option, but there have been problems with PACE not being provided as an option in the SPD expansion.

John Shen, DHCS, replied that the Department recognizes that many of the ideas for duals integration come from programs like PACE. The Department is currently working to figure out how to tap into existing service programs and providers in conjunction with the duals pilots. *Toby Douglas* noted that John Shen has a long history with On Lok and PACE, and is familiar with these issues.

Next Steps, Next Meetings and Adjourn

Toby Douglas, DHCS, thanked the meeting participants, and said that *ad hoc* groups would be reconvened on SPDs, LIHP, and behavioral health assessment. He said that DHCS would continue to engage stakeholders on the CCS transition and the work on dual eligibles.

In addition DHCS will expand the focus of this group to include health care reform activities both in and outside the waiver, including looking at transforming eligibility and enrollment systems

and other issues that affect DHCS along with the Exchange or MRMIB. Future meetings will be longer, and DHCS will be asking participants for additional topics.

The meeting was adjourned at 12:35.